5.0.0 BLINDNESS & DISABILITY

5.1.0 Determination of Disability

Disability and blindness determinations are made by the Disability Determination Bureau (DDB) in the Department of Health and Family Services. The Economic Support Agency (ESA) should submit an application for a disability determination even if the client has already applied for SSI or SSDI. Send applications, medical reports and releases to:

Regular Mail	**Certified Mail**
Disability Determination Bureau P.O. Box 7886 Madison, WI 53707-7886	Disability Determination Bureau 722 Williamson Street Madison, WI 53703-3546

A DDB disability decision on a SSDI or SSI case generally has binding authority. A Medicare or SSDI disability certification notice is acceptable verification of disability.

To check on the status of a disability case, call (608) 266-1565 and DDB will connect you with the examiner assigned to the case. Direct procedural or policy questions to Terri Klubertanz at (608) 266-7604.

Pend the case in CARES while you are waiting for a disability decision from DDB. Go to ANDI and enter a "?" in the disability verification field. Extend the date on AGVC and send a manual notice telling the client that eligibility is pending the disability decision. Remind him/her to report any changes within 10 days.

5.1.1 Defintion of Disability

The law defines disability for Medicaid (MA) as: 'The inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.' Substantial gainful activity is currently defined as gross income of $800 or more per month. See 5.9.0 for the Medicaid Purchase Plan (MAPP) disability definition.

5.2.0 Application Process

5.2.1 Information Form

Give an Information for Medicaid - Disability Applicants form (DES 3071A) to each person applying for MA Disability.

5.2.2 Application Form

Give each applicant a Medicaid-Disability Application form (DES 3071).

Make sure the form is filled out completely with names and addresses of all medical sources that have treated the applicant.

Applicants must list **all** of their medical problems.

5.2.2 Application Form (cont.)

An applicants' employment background is important in determining disability in most cases. The more information you can provide the better. DDB must have a 15-year work history. Detailed information about current work is necessary in all cases.

DDB may consider a medical onset of disability date going back to the first of the month, three months prior to the date of the signed application.

5.2.3 Release Form

Ask the applicant to sign a Confidential Information Release Authorization – Release to Disability Determination Bureau form (HFS-9D) for each medical source identified on the application form plus several additional copies. (Some hospitals and institutions require a release for each department.) **This is the only form DDB can accept**.

Leave the box blank that asks for the “Name and Address – Agency/Organization Authorized to Release Information.” DDB has scanners that will automatically fill in the blank. Filling it in creates problems for them.

Applications for disability made by the applicant must include releases that are signed personally by the disabled applicant. Applications made on behalf of a disabled applicant must be accompanied by release forms signed by a legally appointed representative. A copy of the court order appointing a representative must be included with the application. An authorized representative’s signature on the release is not acceptable unless s/he has a court order.

5.2.4 Medical Report

A medical report of disability does not need to be submitted with the application. DDB will obtain all of the medical reports necessary for the disability determination.

If the applicant has copies of any medical records, school records, etc., include them with the application. See 5.1.0 for the DDB address.

Applications that are not fully completed with names and addresses and work information will be returned to the local ESA.

5.2.5 SSI Application Date

Occasionally a person applies for SSI and is determined ineligible for SSI payments. In these cases, determine MA eligibility from the SSI application date, if it is earlier than the ES application date.

5.2.5 SSI Application Date (cont.)

An application for SSI is also an application for MA.

S/he must still meet all MA eligibility requirements. You must request the SSI application date by using the state on line query (SOLQ). Use the SSI application date as the filing date if the client contacts the ESA within the calendar month following the month of the SSI denial. If the contact to the ESA is later than the above, the filing date is the regular date s/he applied at the ESA.

5.2.6 Routine SSI-MA Extension

The ESA fills the gap in eligibility between the loss of SSI-MA and an eligibility determination by the ESA. Certify the client for the period between the loss of SSI-MA eligibility that appears on MMIS and when you will be able to determine their MA eligibility. Determining MA eligibility should usually occur within the month after s/he loses SSI.

When a person applies for SSI and is denied, there is no obligation to "fill gaps." The exception to this is in 5.2.5.

The ES agency will fill the gap in eligibility when an ongoing SSI case is terminated. The person is eligible for a re-determination of MA eligibility by the ESA. S/he should apply within the calendar month of notification of termination. An extra month of SSI-MA eligibility is posted on MMIS to allow the client time to have eligibility determined by the ESA.

There is no fill the gap provision for those who lose their SSI eligibility because of:

A. Death
B. Leaving Wisconsin
C. Incarceration
D. Fleeing drug felon

5.2.6.1 Case Processing

The processes differ based on if the client is already open for another program in CARES or if they aren't open in CARES. The starting point for both CARES and non-CARES cases is an MMIS and SOLQ query.

Active CARES cases- An active case in CARES is one in which the person is part of a case where at least one person is currently open, or closed less than 30 days for at least one program of assistance. If the client has an active case in CARES, EDS sends a list to the agency's CARES coordinator of those losing SSI and sends those clients a letter saying the ES worker will contact them if there isn't enough information to determine eligibility.

5.2.6.1 Case Processing (cont.)

As soon as the ES worker receives the list of those in active CARES cases, s/he:

1. Opens the client for MA in CARES. This may seem unusual since s/he will show eligibility on MMIS for a grace month. The reason you open all of them in CARES is to provide a tracking mechanism to show you "filled the gap" and that the client receives the correct notice, if s/he fails eligibility later. CARES instructions are:

   a. ACPA- Request MA

   b. ANBR- Change the Y in the SSI field to N or on ANBC – change the Y in the 1619(b) field to N.

   c. Don't change any financial information (unless you need to in order to make the person eligible).

   d. Complete any other required demographic information.

   e. Verifications aren't required at this point.

   f. Run eligibility and confirm.

2. The day after you open the case, request verification of any items you need to determine continued MA eligibility. At this point, treat the case as a regular case, and all verification rules, etc. apply. The client has 10 days to provide verifications.

   Non CARES- If the client doesn't have an active case on CARES, EDS sends a letter along with an application telling him/her that s/he must apply. The client sends the application to EDS and EDS forwards it to the CARES coordinator, who assigns it to a worker. The worker enters the case and determines eligibility. MMIS will close those cases that do not send an application within 30 days of their request.

3. **Reminder**: For all cases, (CARES and Non-CARES) even if the client doesn't meet MA eligibility requirements for the months between when s/he lost SSI and when you are re-determining eligibility, s/he is still eligible. Don't require the client to come into the office. Ineligibility starts, following timely notice, when s/he:

5.2.6.1 Case Processing (cont.)

1. Does not return the application (EDS takes care of this **or**
2. Fails to respond to an information request, **or**
3. No longer meets eligibility requirements (only forward from when the review or application is done).

5.2.7 Other SSI-MA Extensions

Fill the gap between the loss of SSI-MA and an eligibility determination by the ESA when:

1. Retroactive SSI approval and termination occurs. A person applies for SSI and is approved. The approval is retroactive and the SSI also is terminated retroactively.

2. Eligibility for MA is not determined timely by the ESA through no fault of the client.

5.3.0 DDB Action

DDB will attempt to process the disability determination within 60 days of the date it receives the signed application. If a delay in processing the application occurs because the extent of an impairment will not be known until several months after its onset, DDB will notify the applicant in writing that additional evaluation time is necessary. DDB will give the reason for the delay and will inform the person of the right to appeal the delay. The ESA will receive a copy of the letter.

5.3.1 Diary Date

Item 17 on the SSA-831 form indicates whether or not medical re-examination is required. An exam is required when improvement is expected to occur in a person's condition. A date on the box to the right of item 17, "Diary Type", tells you when DDB wants to review the case again. When the Diary Date is earlier than the current date refer to the instructions that follow under Redetermination (5.6.0).

5.3.2 Allowances

Files on persons found disabled will be returned to the ESA with a completed SSA-831 Determination of Disability.

5.3.3 Denials

Persons found not disabled will be sent a notice by DDB (a copy will be sent to the ESA) along with forms to apply for a Reconsideration/Hearing. Files on denied cases will be kept at DDB for 60 days. If the ES agency needs a file after 60 days, call Robin Kast at (608) 266-3300 and the files will be returned to the ESA.

5.4.0 Reconsideration/ Hearing

Send Reconsideration/Hearing requests to:

Disability Determination Bureau
Medicaid Reconsideration Unit
P.O. Box 7886
Madison, WI 53707-7886.

Requests for Reconsideration/Hearing must be received by DDB within 45 days of the date of the Denial Notice.

DDB will conduct a reconsideration of the denial. If DDB reverses the decision to an allowance, the determination and folder will be sent to the ESA.

If DDB affirms the denial, a Reconsideration Denial notice will be sent to the applicant (a copy will be sent to the ESA) and the file will be sent directly to the Division of Hearings and Appeals, which will then schedule a hearing.

If, in a fair hearing, a person is found to be disabled, and the hearing officer does not specify a date for review, contact DDB and request a date to review the disability.

5.5.0 Medical Exam Cost

If the person's MA application is approved, MA will pay the cost of any medical examination necessary for the completion of a current medical report. If it is denied, you may claim the cost of the examination as an administrative expense. Reimbursement is from the MA administrative account.

5.6.0 Redetermination

Review a disability determination when:

1. The Disability Determination and Transmittal (SSA-831) indicates medical re-examination in item 17 of that form, **or**
2. The person no longer receives OASDI (Social Security) disability benefits, **or**
3. The medical circumstances have significantly improved, **or**
4. The person has returned to work.

Complete and/or forward the following to DDB:

1. MA Disability Redetermination Report.
2. Signed Confidential Information Release forms. See 5.2.2.

5.6.0 Redetermination

3. The original Disability Determination form (SSA-831) and any subsequent disability determinations and all prior medical evidence and forms.

DDB will make a decision, which will be indicated on a Cessation or Continuance of Disability form (SSA-833).

Item 9 (SSA-833) indicates the decision of (A) continuing, or (B) ceased.

Item 23B (SSA-833) indicates a medical re-examination date when necessary.

5.7.0 Conflicting Claims

Disability determinations for Social Security, SSI and Medicaid are completed under the same regulations. DDB's decisions will be consistent if the person files for any of these programs. If a decision on one program is later changed by appeal or because of new evidence, etc., DDB will notify the other program's to change their determinations to match.

DDB may request return of MA disability files when reviews of conflicting or updated decisions are needed.

5.8.0 Presumptive Disability

Presumptive Disability (PD) is a method for authorizing emergency MA coverage prior to a formal disability determination by DDB. To qualify for PD, the person must meet the following conditions:

1. S/he must be a patient in a hospital and his/her discharge from the hospital is being delayed either because long-term care is needed and the care facility will not admit her/him until MA is approved, or because necessary in-home services cannot be obtained without MA, **or**

2. S/he has a major health condition that would prevent all work activity for 12 months or result in death, or a major organ transplant (heart, lung, kidney, liver, or pancreas).

A request for a Presumptive Disability may be faxed to DDB at (608) 266-8297. The request **must** include a fully completed application form (see 5.2.2) and the appropriate number of release forms (see 5.2.3). Fax these materials under a copy of the form at the end of this appendix. The name, telephone and Fax numbers of worker submitting the request **must** be included on the Request for Medicaid Presumptive Disability Decision fax cover request.

5.8.0 Presumptive Disability (cont.)

It is not necessary to obtain a statement from a physician, however the application should have detailed information concerning the alleged disabilities and current status.

If the applicant is currently hospitalized or was recently hospitalized, it is recommended that hospital records be submitted with the request. If such records are not immediately available, do not delay the request to obtain the records. DDB will make the records requests.

15.8.2 DDB Processing

DDB will attempt to reply to faxed PD requests within 3 days The PD decision depends on the likelihood of the applicant being found disabled when full medical documentation is obtained for a final determination.

Federal regulations generally require the evaluation of certain disabilities after a three month period of recovery from the original injury or medical event (major head injuries, strokes, heart attacks, etc.) It may not be possible to establish disability, either on a presumptive or final basis during that period. However, all applications should be submitted and a complete medical review will be made.

5.8.3 Eligibility

PD-MA coverage begins on the date DDB makes the presumptive disability decision.

Do not grant retroactive eligibility until DDB makes a formal disability determination, (when the case folder is returned to the ESA). Once DDB does the final determination, the case may be backdated up to three months prior to the month of application but no earlier than the date of disability onset, provided all other eligibility requirements are met.

5.8.4 Denial

If there is evidence to justify denial for nonmedical reasons, you may terminate PD with proper notice without waiting for DDB's final disability decision. In such a case, notify DDB immediately at, (608) 266-1565, that a medical determination is no longer needed.

If the DDB reverses the PD decision, follow the usual discontinuance procedures (IMM, Ch. I). Eligibility based on PD does not continue during the period a person is appealing DDB's decision to deny PD.

5.9.0 MAPP

When a disability determination for the MAPP is required, complete the application process in 5.2.0 above.

Sections 12 and 13 of the Application for MA Disability form (DES 3070A) must be completed in full detail in all MAPP disability determination requests. Requests for a MAPP disability determination should be accompanied by a letter specifying whether the request is for a MAPP disability determination, or both a regular MA disability determination and a MAPP disability. It is advisable to have both determinations completed if an applicant may move from regular Medicaid disability to MAPP disability.

A determination of disability for MAPP excludes consideration of Substantial Gainful Activity (SGA), while a regular MA disability determination does not.